This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or **plan** document at www.blueshieldca.com or by calling 1-800-642-6155.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 3 for your costs for services this **plan** covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes. For Signature Level I HMO: **$1,500** per individual **/ $3,000** per family For Signature Level II **preferred**: **$0** per individual **/ $0** per family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, some **copayments**, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the **plan** will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **providers**, see www.blueshieldca.com or call **1-800-642-6155**.	If you use an **in-network** doctor or other health care **provider**, this **plan** will pay some or all of the costs of covered services. Be aware, your **in-network** doctor or hospital may use an **out-of-network provider** for some services. **Plans** use the term **in-network**, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this **plan** pays different kinds of **providers**.

Questions: Call 1-800-642-6155 or visit us at www.blueshieldca.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	Yes. For Signature Level I HMO **providers**, members must receive a referral. For Signature Level II **preferred providers**, members do not need a referral.	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have the **plan's** permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this **plan** doesn't cover are listed on page 6. See your policy or **plan** document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the **plan's allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an **out-of-network** hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This **plan** may encourage you to use Signature Level I HMO **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Signature Level I HMO Plan Provider	Your Cost If You Use a Signature Level II Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 / visit	$30 / visit	————None————
	Specialist visit	$10 / visit	$30 / visit	————None————
	Other practitioner office visit	Not Covered	Not Covered	————None————
	Preventive care/ screening/ immunization	No Charge	$30 / visit	————None————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge in physician's office Not Covered at freestanding lab/x-ray center	————None————
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered at freestanding diagnostic center	————None————

Common Medical Event	Services You May Need	Your Cost If You Use a Signature Level I HMO Plan Provider	Your Cost If You Use a Signature Level II Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueshieldca.com	Generic drugs	From participating pharmacy **providers**: $5 / prescription (retail) $10 / prescription (mail)	From non-participating pharmacy **providers**: Not Covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail). Select formulary and non-formulary drugs require prior authorization.
	Preferred brand drugs	From participating pharmacy **providers**: $10 / prescription (retail) $20 / prescription (mail)	From non-participating pharmacy **providers**: Not Covered	
	Non-preferred brand drugs	From participating pharmacy **providers**: $25 / prescription (retail) $50 / prescription (mail)	From non-participating pharmacy **providers**: Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Signature Level I HMO Plan Provider	Your Cost If You Use a Signature Level II Preferred Provider	Limitations & Exceptions
	Specialty drugs	From participating pharmacy **providers**: $10 / prescription	From non-participating pharmacy **providers**: Not Covered	Covers up to a 30-day supply. Prior authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——————None——————
	Physician/surgeon fees	No Charge	Not Covered	——————None——————
If you need immediate medical attention	Emergency room services	$50 / visit	$50 / visit	——————None——————
	Emergency medical transportation	No Charge	No Charge	——————None——————
	Urgent care	$10 / visit	$10 / visit	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——————None——————
	Physician/surgeon fee	No Charge	Not Covered	——————None——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	First 3 Visits: No Charge, then $10/visit	First 3 Visits: No Charge, then $10/visit	——————None——————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	——————None——————
	Substance use disorder outpatient services	First 3 Visits: No Charge, then $10/visit	First 3 Visits: No Charge, then $10/visit	——————None——————
	Substance use disorder inpatient services	No Charge	Not Covered	——————None——————
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	——————None——————

Common Medical Event	Services You May Need	Your Cost If You Use a Signature Level I HMO Plan Provider	Your Cost If You Use a Signature Level II Preferred Provider	Limitations & Exceptions
	Delivery and all inpatient services	No Charge	Not Covered	————None————
If you need help recovering or have other special health needs	**Home health care**	No Charge	Not Covered	————None————
	Rehabilitation services	$10 / visit	$30 / visit	For Signature Level II **providers**, up to 12 visits per calendar year.
	Habilitation services	$10 / visit	$30 / visit	For Signature Level II **providers**, up to 12 visits per calendar year.
	Skilled nursing care	No Charge	Not Covered	————None————
	Durable medical equipment	No Charge	Not Covered	————None————
	Hospice service	No Charge	Not Covered	————None————
If your child needs dental or eye care	Eye exam	No Charge	$30 / visit	————None————
	Glasses	Not Covered	Not Covered	————None————
	Dental check-up	Not Covered	Not Covered	————None————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Routine eye care (Adult/Child)

Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the **plan** at 1-800-642-6155. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-800-642-6155 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your **appeal**. Contact the California Department of Managed Health Care at (888) 466-2219 or helpline@dmhc.ca.gove or visit http://www.healthcarehelp.ca.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-866-346-7198**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-346-7198**.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-866-346-7198**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-346-7198**.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next page.*

About these Coverage Examples:

These examples show how this **plan** might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different **plans**.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,380
- **Patient pays** $160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$0
Copayments	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$160**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,020
- **Patient pays** $380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$0
Copayments	$300
Coinsurance	$0
Limits or exclusions	$80
Total	**$380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health **plan**.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from **in-network providers**. If the patient had received care from **out-of-network providers**, costs would have been higher.
- **Plan** and patient payments are based on a single person enrolled on the **plan** or policy.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health **plan** allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other **plans**, you'll find the same Coverage Examples. When you compare **plans**, check the "Patient Pays" box in each example. The smaller that number, the more coverage the **plan** provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.